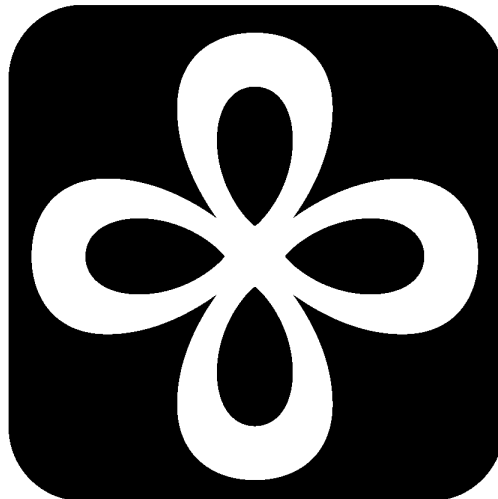


**STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES**

MEDICAID




Provider Manual

Psychiatric Medical Institutions for Children

**CHAPTER E****COVERAGE AND LIMITATIONS**Page

I.	FACILITIES ELIGIBLE TO PARTICIPATE.....	E-1
II.	COVERAGE OF INPATIENT SERVICES	E-1
A.	Certification of Need for Inpatient Care.....	E-2
1.	Facility Assessment.....	E-2
2.	Independent Assessment	E-3
3.	Certification of Need for Inpatient Psychiatric Services, Form 470-2780	E-3
B.	Covered Services.....	E-5
C.	Plan of Care.....	E-5
D.	Interdisciplinary Team.....	E-6
E.	Recipient Eligibility	E-7
F.	Children in Managed Health Care.....	E-8
G.	Case Activity Report, Form AA-4166-0	E-8
III.	COVERAGE OF DAY TREATMENT	E-11
A.	Program Requirements	E-11
B.	Programming.....	E-13
C.	Admission Criteria	E-16
D.	Individual Treatment Plan.....	E-17
E.	Discharge Criteria.....	E-18
F.	Coordination of Services.....	E-19
G.	Stable Milieu	E-20
H.	Documentation	E-20
IV.	BASIS OF PAYMENT FOR INPATIENT SERVICES	E-22
A.	Client Participation.....	E-22
B.	Personal Needs Funds	E-23
C.	Reserve Bed Days.....	E-25
1.	Visits	E-25
2.	Hospital Leaves	E-26
3.	Other Absences for Foster Children.....	E-27
V.	BASIS OF PAYMENT FOR OUTPATIENT SERVICES.....	E-27

 Iowa Department of Human Services	CHAPTER SUBJECT: TABLE OF CONTENTS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	PAGE 5
		DATE November 1, 1999

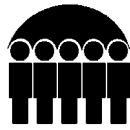
Page

CHAPTER F. BILLING AND PAYMENT

I.	INSTRUCTIONS AND CLAIM FORM	F-1
A.	Instructions for Completing the Claim Form	F-1
B.	Facsimile of Claim Form, UB-92 (front and back).....	F-37
II.	REMITTANCE ADVICE AND EXPLANATION.....	F-37
A.	Remittance Advice Explanation.....	F-37
B.	Facsimile of Outpatient and Inpatient Remittance Advice.....	F-38
C.	Outpatient Remittance Advice Field Descriptions	F-43
D.	Inpatient Remittance Advice Field Descriptions.....	F-45

APPENDIX

I.	ADDRESSES OF COUNTY HUMAN SERVICES OFFICES	1
II.	ADDRESSES OF SOCIAL SECURITY ADMINISTRATION OFFICES	9
III.	ADDRESSES OF EPSDT CARE COORDINATION AGENCIES.....	13



I. FACILITIES ELIGIBLE TO PARTICIPATE

Psychiatric medical institutions for children (PMICs) are eligible to participate in the Medicaid program if they meet all of the following conditions.

- ◆ Be accredited by a federally recognized accrediting organization, such as
 - The Joint Commission on the Accreditation of Health Care Organization,
 - The Commission on Accreditation of Rehabilitation Facilities,
 - The Council on Accreditation of Services for Families and Children, or
 - Any other organization with comparable standards.
- ◆ Have been issued a license by the Department of Inspections and Appeals.
- ◆ Have been awarded a Certificate of Need from the Department of Public Health.
- ◆ Have received written approval of need from the Department of Human Services, Division of Adult, Children and Family Services.
- ◆ Be in compliance with all applicable state rules and standards regarding the operation of comprehensive residential facilities for children.

Facilities providing outpatient day treatment for children or adolescents require approval from the Department of Inspections and Appeals.

II. COVERAGE OF INPATIENT SERVICES

Medicaid coverage is available for PMIC services when:

- ◆ The conditions for service to the child are met,
- ◆ The child is determined to meet the level of care criteria, and
- ◆ The child is eligible for Medicaid.



The following sections give more information on:

- ◆ Certification of the need for inpatient care.
- ◆ PMIC services covered by Medicaid.
- ◆ Requirements for a plan of care.
- ◆ Requirements for an interdisciplinary team.
- ◆ Medicaid eligibility for recipients receiving PMIC care.
- ◆ Procedures required to obtain coverage for children under managed health care.
- ◆ Use of the *Case Activity Report*, form AA-4166-0.

A. Certification of Need for Inpatient Care

In order to receive Medicaid payment for a child entering a PMIC, the facility must have an assessment certifying all of the following:

- ◆ Ambulatory care resources available in the community do not meet the child's treatment needs.
- ◆ Proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- ◆ Inpatient services can reasonably be expected to improve the child's condition or prevent further regression, so that the ongoing services will no longer be needed.

The following sections address:

- ◆ When this assessment can be made by the facility.
- ◆ When an independent team must make the assessment.
- ◆ Use of form 470-2780, *Certification of Need for Inpatient Psychiatric Services*.

1. Facility Assessment

For children who are not Medicaid-eligible at the time of entry or who have only applied for Medicaid, the interdisciplinary team within the facility must perform the review within 14 days after admission. The review must cover any period before application for which claims are to be made.

For emergency admissions of Medicaid recipients, the interdisciplinary team must provide a certification within 14 days of admission. An "emergency"



admission is an admission that is required because the health of the child is in immediate jeopardy.

2. Independent Assessment

Children who are in foster care or have a Medicaid card before they go to the facility must be certified through an independent assessment performed by a team. None of the team members may have an employment or consultation relationship to the admitting facility.

The assessment team must include a physician and another professional. The physician should have competence in the diagnosis and treatment of mental illness and have knowledge of this child's situation. This may be accomplished through a community mental health center or a family physician with a Department social worker, a juvenile court officer, or another professional.

The assessment must be performed within 45 days before the proposed date for admission to the facility and be submitted to the facility on or before the date of the child's admission.

3. Certification of Need for Inpatient Psychiatric Services, Form 470-2780

Form 470-2780, *Certification of Need for Inpatient Psychiatric Services*, can be used to ensure the admission assessment is performed and meets the required criteria. See the next page for a facsimile of this form.

Iowa Department of Human Services

CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES

Name of Child	Birthdate
---------------	-----------

INDEPENDENT TEAM ASSESSMENTYesNo

(Please check one choice for each item.)

☐☐

1. Available community resources for ambulatory care do not meet the treatment needs of this child.


☐☐

2. Proper treatment of this child's psychiatric condition requires service on an inpatient basis, under the direction of a physician.

☐☐

3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed.

Physician Name	Date
Name and Profession	Date
Name and Profession	Date
Name and Profession	Date
Name and Profession	Date

 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE E - 5
		DATE November 1, 1999

B. Covered Services

All inpatient psychiatric services are covered services when the admission or continued stay is approved by the Iowa Foundation for Medical Care (IFMC). Facilities must notify the IFMC of planned admissions by calling 1-800-383-1173 and asking for PMIC reviewer.

Facilities bill Medicaid separately for such services as prescription drugs, eyeglasses, and physician services. Psychological services are the responsibility of the facility. Other services in the plan of care that are not covered by the Medicaid program are also the responsibility of the facility.

Educational and vocational training are not reimbursable.

C. Plan of Care

Inpatient psychiatric services must include active treatment. “Active treatment” means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team.

A team of professionals, as specified below, must develop the plan of care no later than 14 days after admission. If possible, develop the plan in consultation with the child and the child’s parents, legal guardians, or others in whose care the child will be released after discharge. The plan of care must:

- ◆ Be based on a diagnostic evaluation and include examination of the medical, psychological, social, behavioral and developmental aspects of the child’s situation and reflect the need for inpatient psychiatric care.
- ◆ Be designed to achieve the child’s discharge from inpatient status at the earliest possible time.
- ◆ State treatment objectives.
- ◆ Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives.
- ◆ Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the child’s family, school, and community upon discharge.



The interdisciplinary team must review the plan every 30 days to:

- ◆ Determine that services being provided are or were required on an inpatient basis.
- ◆ Recommend changes in the plan as indicated by the child's overall adjustment as an inpatient.

D. Interdisciplinary Team

An "interdisciplinary team" is a team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility.

Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are:

- ◆ Involved in the direct provision of treatment services,
- ◆ Involved in the organization of the plan of care, or
- ◆ Involved in consulting with or supervising those professionals involved in the direct provision of care.

The team must include at a minimum either:

- ◆ A board-eligible or board-certified psychiatrist, or
- ◆ A clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or
- ◆ A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

The team must also include one of the following:

- ◆ A social worker with a master's degree in social work and specialized training or one year's experience in treating persons with mental illness.
- ◆ A registered nurse with specialized training, or one year of experience in treating persons with mental illness.
- ◆ A licensed occupational therapist who has specialized training or one year of experience in treating persons with mental illness.
- ◆ A psychologist who has a master's degree in clinical psychology or who has been licensed by the state.



Based on education and experience, preferably including competency in child psychiatry, the team must be capable of:

- ◆ Assessing the child's immediate and long-range therapeutic needs, developmental priorities, personal strengths, and liabilities.
- ◆ Assessing the potential resources of the child's family.
- ◆ Setting treatment objectives.
- ◆ Prescribing therapeutic modalities to achieve the plan's objectives.

E. Recipient Eligibility

To be financially eligible for payments for the cost of inpatient care provided by a PMIC, a person must be under the age of 21 and be eligible for Medicaid.


Exception: No payment at all is made if the child is eligible under the Medically Needy coverage group.

The facility should require that a Medicaid application be filed for every foster child who is not already eligible for Medicaid. The local Department income maintenance worker determines eligibility.

Both Department income maintenance and service workers and also juvenile court officers have responsibilities when a child is court-ordered into foster care in a PMIC. A Medicaid card may not be issued until all bases of eligibility are established to determine the availability of federal funding.

An eligible child is considered to be an inpatient until the child is unconditionally discharged or the child attains age 21. When inpatient treatment is provided immediately before the child's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier. Coverage extends until the last day of the month of the discharge or the twenty-second birthday.

The Department must conduct a six-month review of eligibility to redetermine if the child remains eligible for federally paid Medicaid. While eligible for Medicaid, the child is entitled to the full scope of Medicaid benefits.

 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE E - 8
		DATE January 1, 2000

F. Children in Managed Health Care

Children in Medicaid HMOs, MediPASS, or the Iowa Plan require special procedures when they enter a PMIC. The service worker has information on managed health care.

A child who is receiving FMAP or FMAP-related Medicaid will automatically be disenrolled from an HMO or MediPASS at the end of the month of entry or the end of the month after entry.

However, until disenrollment occurs, a prior authorization is required for Medicaid payment of medical services. Contact the managed health care provider to obtain any necessary authorization to ensure payment. Nonemergency services provided without a referral may not be paid.

Payment for services other than the facility (such as a psychiatrist's services) is subject to the authorization of the managed health care provider until the child is disenrolled.

G. Case Activity Report, Form AA-4166-0

The *Case Activity Report*, form AA-4166-0, is a report of new residents and changes in the status of current residents. When a resident applies for Medicaid, you must send a *Case Activity Report* to the income maintenance worker in the Department's county office.

You must also reported to the county office any changes associated with Medicaid residents, including any change in level of care decisions by the IFMC, hospital admissions, visits out of the facility, runaways, and discharges or death.

For foster care children, the service worker may require more specific information to be reported.

Iowa Department of Human Services

CASE ACTIVITY REPORT

Complete this form when a Medicaid applicant or recipient enters or leaves your facility, and when a resident of your facility applies for Medicaid. See the back of this form for instructions.

--	--

Fold line 1. Recipient Data**Fold**

Name	Social Security Number	State ID	Date Entered Facility
------	------------------------	----------	-----------------------

2. Facility Data

Name	Provider Number	DHS Per Diem
City	Signature of Person Completing Form	Date Completed

3. Level of Care

This information is determined by (IFMC, Medicare or by managed care contractor). Provider number in Item 2 must match the new level of care.

Level of Care	Effective Date
---------------	----------------

4. Medicare Information for Skilled Patients in Skilled Facilities

Do you expect this stay to be covered by Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes, see dates: _____ through _____	Expected dates of full Medicare coverage _____ through _____	Expected dates of partial Medicare coverage _____ through _____
--	---	--

If there is any change in this coverage, please notify the county DHS office.

5. Discharge Data

Date of Discharge <u>Last Month in Facility</u> (for residents who transfer to another facility or level of care): _____ Days in facility _____ Reserve bed days _____ Non-covered days _____ Total billing days on claim to fiscal agent	Reason for Discharge <input type="checkbox"/> Died <input type="checkbox"/> Transferred to another facility Name _____ Level of care, if known _____ <input type="checkbox"/> Moved to new living arrangement Address, if available _____
--	---

Instructions for Preparing the Case Activity Report:

- ◆ When a current resident applies for Medicaid, complete Sections 1-3. Enter the first name, middle initial, and last name of the resident as they appear on the Medical Assistance Eligibility Card. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1100234G.
- ◆ When a Medicaid applicant or recipient enters the facility or changes level of care, complete sections 1-3, and section 4, if applicable.
- ◆ When a Medicaid applicant or recipient dies or is discharged, complete Sections 1 and 5.
- ◆ This form must be completed within 2 business days of the action.
- ◆ The administrator or designee responsible for the accuracy of this information should sign in Section 2. The date is the date the form is completed and sent to the county Department of Human Services office.


Distribution Instructions for RCFs

Mail the white copy to your county DHS worker. Keep the yellow copy. Discard the pink copy.

Distribution Instructions for NFs, ICF/MRs, SNFs, Mental Health Institutes and Psychiatric Medical Institutions for Children

Mail the white copy to your county DHS worker. Mail the yellow copy to IFMC. Keep the pink copy.

IFMC Address: Iowa Foundation for Medical Care
6000 Westown Parkway Ste 350
West Des Moines IA 50265

 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE
		E - 11 <hr/> DATE November 1, 1999

III. COVERAGE OF DAY TREATMENT

Day treatment services for persons aged 20 or under are outpatient services provided to persons who are not inpatients in a medical institution or residents of a licensed group care facility. Payment is made for day treatment services provided in an approved site. Day treatment coverage is limited to a maximum of 15 hours per week.

PMICs with day treatment programs for persons aged 20 or under must address:

- ◆ Documented need for day treatment services for children in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.
- ◆ Goals and objectives of the program that meet the guidelines below.
- ◆ Organization and staffing, including how the program fits with the PMIC, the number of staff, staff credentials, and the staff's relationship to the program (employee, contractual, or consultant).
- ◆ Policies and procedures for the program, including admission criteria, patient-assessment, treatment plan, discharge plan, and postdischarge services, and the scope of services provided.

A. Program Requirements

Day treatment programs must be a separate program from the inpatient program and must meet the following criteria:

- ◆ Staffing must be sufficient to deliver program services and provide stable, consistent, and cohesive milieu. Staffing plans must reflect how program continuity will be provided.
- ◆ Staffing must reflect an interdisciplinary team of professionals and paraprofessionals.
- ◆ Staffing must include a designated director who is a mental health professional. The director must be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.



- ◆ The program must have a staff-to-patient ratio of no less than one staff for each six participants. Clinical, professional, educational, and paraprofessional staff may be counted in determining the staff-to-patient ratio.

Professionals or clinical staff are those staff who are either mental health professionals as defined in 441 Iowa Administrative Code 24.1(225C) or persons employed for the purpose of providing offered services under the supervision of a mental health professional.

All other staff must not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. (This includes administrative, adjunctive, support, nonclinical, clerical, and consulting staff and professional or clinical staff when engaged in administrative, clerical, or support activities.)

- ◆ Services must be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the PMIC who is not a mental health professional, the employee or consultant must be supervised by a mental health professional. The employee or consultant must:
 - Have a minimum of a bachelor's degree in a human services related field from an accredited college or university or
 - Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

The supervising mental health professional must give direct professional direction and active guidance to the employee or consultant and retain responsibility for consumer care. The supervision must be timely, regular and documented.

- ◆ The program must have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.
- ◆ Programming must meet the individual needs of the patient. A description of services provided for patients must be documented along with a schedule of when service activities are available including the days and hours of program availability.
- ◆ There must be a written plan for accessing emergency services 24 hours a day, seven days a week.



- ◆ The program must maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships must exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships must also exist with appropriate school districts and educational cooperatives.

Relationships with other entities, such as physicians, hospitals, private practitioners, halfway houses, the Department, juvenile justice system, community support groups, and child advocacy groups, are encouraged. The provider's program description must describe how community links will be established and maintained.

- ◆ Psychotherapeutic treatment services and psychosocial rehabilitation services must be available. A description of the services must accompany the application for certification.

The provider must meet the PMIC license requirements, except that staff/patient ratios of one to six is acceptable.

B. Programming

Day treatment services for children must be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. "Time-limited" means that:

- ◆ The patient is not expected to need services indefinitely or life long, and
- ◆ The primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary.

Day treatment services must be provided within the least restrictive therapeutically appropriate context and must be community-based and family-focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family. At a minimum, day treatment services are expected to:

- ◆ Improve the patient's condition,
- ◆ Restore the condition to the level of functioning before the onset of illness,
- ◆ Control symptoms, or
- ◆ Establish and maintain a functional level to avoid further deterioration or hospitalization.



Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs must use an integrated, comprehensive and complimentary schedule of therapeutic activities, and must have the capacity to treat a wide array of clinical conditions. The following services must be available as components of the day treatment program.

- ◆ Psychotherapeutic treatment services (such as individual, group, and family therapy).
- ◆ Psychosocial rehabilitation services. Active treatment examples include, but are not limited to:
 - Individual and group therapy,
 - Medication evaluation and management,
 - Expressive therapies, and
 - Theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

- ◆ Evaluation services. Evaluation services must determine need for day treatment before program admission. An evaluation service may be performed when clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria.

Evaluation services must be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional.



An evaluation from another source performed within the previous 12 months may be substituted if there has not been a change. Medicaid will not make separate payment for these services under the day treatment program.

- ◆ Assessment services. All day treatment patients must receive a formal, comprehensive bio-psycho-social assessment of day treatment needs, including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. The assessment must address whether medical causes for the child's behavior have been ruled out.

An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same. If not, parts of the assessment that reflect current functioning may be used as an update.

Using the assessment, produce a comprehensive summation, including the findings of all assessments performed. Use this summary in forming a treatment plan including treatment goals.

Also consider and consistently monitor indicators for discharge planning, including recommended follow-up goals and provision for future services.


- ◆ Educational component. The patient's educational needs must be served without conflict from the day treatment program. The day treatment program may include an educational component as an additional service.

Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid. The day treatment program may wish to pursue funding of educational hours from local school districts. Example:

The patient attends the day treatment program from 9:00 a.m. to 3:00 p.m. The patient attends the educational component from 9:00 a.m. to noon.

The hours the patient attends the educational component are deducted from the day treatment hours. The billable day treatment hours for Medicaid are three hours (noon to 3:00 p.m.).

These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

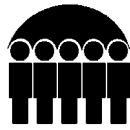
 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE
		E - 16 <hr/> DATE November 1, 1999

C. Admission Criteria

The admission criteria for day treatment for people aged 20 or under are:

- ◆ The patient is at risk for exclusion from normative community activities or residence due to factors such as:
 - Behavioral disturbance.
 - Chemical dependence.
 - Depression.
- ◆ The patient exhibits some of the following symptoms:
 - Psychiatric symptoms.
 - Disturbances of conduct.
 - Decompensating conditions affecting mental health.
 - Severe developmental delays.
 - Psychological symptoms.
 - Chemical dependency issues.
- ◆ These symptoms are sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- ◆ Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate. This includes individual or group therapy services provided by:
 - A physician or psychologist in the provider's office.
 - Auxiliary staff of a physician in the physician's office.
 - A mental health professional employed by a community mental health center.
- ◆ The patient's principle caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, and to enable adequate control of the patient's behavior. The caretaker must be involved in the patient's treatment.

If the principle caretaker is unable or unwilling to participate in the provision of services, the day treatment program must document how services will benefit the child without caretaker involvement. People who have reached majority, either by age or emancipation, are exempt from family therapy involvement.



- ◆ The patient has the capacity to benefit from the interventions provided.

Examples:

- A patient with a diagnosis of mental retardation may not be appropriate for a day treatment program if the patient is unable to participate and benefit from group milieu therapy.
- A patient exhibiting acute psychiatric symptoms (e.g., hallucinations) may be too ill to participate in the day treatment program.

D. Individual Treatment Plan

Prepare a treatment plan for each patient receiving day treatment services. The treatment plan must be developed or approved by one of the following:

- ◆ A board-eligible or board-certified psychiatrist.
- ◆ A staff psychiatrist.
- ◆ A physician.
- ◆ A psychologist registered on:
 - The National Register of Health Service Providers in Psychology or
 - The Iowa National Register of Health Service Providers in Psychology.

Evidence approval by a signature of the physician or health service provider in psychology.

Formulate a preliminary treatment plan within three days of program participation after admission. Replace it within 30 calendar days by a comprehensive, formalized plan using the comprehensive assessment.

This individual treatment plan should reflect the patient's diagnosis and the patient's strengths and weaknesses and identify areas of therapeutic focus. Relate the treatment goals (general statements of consumer outcomes) to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Outline:

- ◆ The hours and frequency the patient will participate in the program.
- ◆ The type of services the patient will receive.
- ◆ The expected duration of the program.



Objectives must be related to the goal and have specific anticipated outcomes. State the methods that will be used to pursue the objectives. Review and revise the plan as needed, but review it at least every 30 calendar days.


E. Discharge Criteria

The length of stay in a day treatment program for children must not exceed 180 treatment days per episode of care. If the patient's condition requires a longer stay, document the rationale for continued stay in the patient's case record and in the treatment plan every 30 calendar days after the first 180 treatment days.

Discharge criteria for the day treatment program for children must incorporate at least the following indicators:

- ◆ If the patient improves:
 - The patient's clinical condition has improved, as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level.
 - Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
 - Treatment goals in the individualized treatment plan have been achieved.
 - An aftercare plan has been developed that is appropriate to the patient's needs, and the patient and the family, custodian, or guardian has agreed to it.
- ◆ If the patient does not improve:
 - The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
 - The patient, the family, or the custodian has not complied with treatment or with program rules.

Postdischarge services must include a plan for discharge that provides appropriate continuity of care.

 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE
		E - 19 <hr/> DATE November 1, 1999

F. Coordination of Services

Provide programming services in accordance with the individual treatment plan. Appropriate day treatment staff must develop the plan in collaboration with the patient and the patient's parent, guardian, or principal caretaker.

The services must be under the supervision of the program director, coordinator, or supervisor. Primary care staff of the PMIC must coordinate the program for each patient.


A coordinated, consistent array of scheduled therapeutic services and activities must comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies.

“Active treatment” is defined as treatment in which the therapist assumes significant responsibility and often intervenes. At least 50 percent of scheduled therapeutic program hours for each patient (exclusive of educational hours) must consist of active treatment components which:

- ◆ Are determined by the individual treatment plan based upon a comprehensive evaluation of patient needs, and
- ◆ Specifically addressing the targeted problems of the population served.

Scheduled therapeutic activities, which may include other program components as described above, must be provided at least three hours per week, up to a maximum of 15 hours per week. Schedule therapeutic activities according to the needs of the patients, both individually and as a group.

The patient's family, guardian, or principal caretaker must be involved with the program through family therapy sessions or scheduled family components of the program. Encourage them to adopt an active role in treatment. Exception: People who have reached majority, either by age or emancipation, are exempt from family therapy involvement. Medicaid does not make separate payment for family therapy services.

 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER	PAGE
		DATE	E - 20 November 1, 1999

G. Stable Milieu

The program must formally seek to provide a stable, consistent, and cohesive therapeutic milieu. Encourage this in part by scheduling attendance such that a stable core of patients exists as much as possible.

Consider the developmental and social stage of the participants, such that no patient is significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning.

To help establish a sense of program identity, the array of therapeutic interventions must be specifically identified as the day treatment program. Program planning meetings must be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider must state how milieu stability will be provided.

H. Documentation

The program must maintain a distinct clinical record for each patient admitted. At a minimum, documentation must include:

- ◆ The specific services rendered,
- ◆ The date and actual time services were rendered,
- ◆ Who rendered the services,
- ◆ The setting in which the services were rendered,
- ◆ The amount of time it took to deliver the services,
- ◆ The relationship of the services to the treatment regimen in the plan of care,
- ◆ Updates describing the patient's progress.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

E - 21

DATE

November 1, 1999

Example 1. John Jones' clinical record

Day treatment services provided June 1, 1999, from 9:00 a.m. to 11:00 a.m. at Brookes PMIC.

Objective: Will develop and maintain a relapse prevention plan including action steps to take in order to stop his offense cycle.

Treatment Note: Arrives late looking very disheveled. Begins with making a lot of excuses with rapid speech and flushed cheeks. Give feedback regarding observing his anxiety at "not being perfect" (trigger for cycle). Went over his thinking ("I'm too busy"), what self-talk would put him back into control (positively). Also informed "my family is moving." Another trigger - discussed strategies for dealing with this to prevent relapse. Joe Brown, MSW

Objective: Increase the use of "I statements" in communications.

Treatment Note: Reports being more open with Mom when Mom makes hurtful comments. States he uses "I statements." He said his Mom often responds saying "you take things too personally." This was discussed and he acknowledged Mom's response intensifies his hurt and anger... but he doesn't continue to express himself. He states he will talk to Mom and continue using "I statements." Suzy Smith, RN

Example 2. Dawn Williams' clinical record:

Day treatment services provided June 2, 1999, from 1:00 p.m. to 4:00 p.m. at Brookes Program.

Objective: Identifies and processes feelings about parental divorce.

Treatment Note: Processed sense of loss. Identified multiple facets to her loss - parental absence, changes in family patterns. Discussed desire to get things "right" in her behavior and parents will reunite.

Interventions: Normalized grief. Empathized with loss. Did reality testing around issue of reconciling parents. Joe Brown, MSW

Objective: Will use weekly play therapy to express feelings.

Treatment Note: Used play time to work on family unity, nurturing and structure themes. Played out resolution to conflict. Also played out her improved self-esteem. Suzy Smith, RN



CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

E - 22

DATE

November 1, 1999

IV. BASIS OF PAYMENT FOR INPATIENT SERVICES

The basis of payment for PMIC services is a prospective reimbursement up to a maximum per day. The prospectively determined rate is based on the cost report information the facility submits to the Medicaid fiscal agent on form SS-1703-0, *Financial and Statistical Report*.

If the facility is established and has the historical data, new facilities have a rate based on historical costs. If the facility is newly established, the rate must be based on a proposed budget submitted on form SS-1703-0. A form SS-1703-0 with actual cost data must be submitted after six months of participation in the program for any rate adjustment.

After the initial cost report period, submit form SS-1703-0 to the Medicaid fiscal agent annually within three months of the close of your fiscal year. The monthly payment is established on the basis of cost information submitted. Adjustments to the rate are made for the first day of the month that Consultec receives form SS-1703.


If you fail to submit cost reports within the required time frames, your rate will be reduced to 75% of the maximum until a cost report is submitted.

Note: Since Medicaid makes payment for these children, they are not eligible for a clothing allowance under the foster care program.

A. Client Participation

Client participation is that share of the child's income that is paid to the facility for facility care. The Department determines client participation and informs the facility with the *Facility Card*, form MA-2139-0. The facility is responsible for collecting the client participation in the amount of client participation indicated on this form.

All income of the child in excess of \$30 per month for personal needs must be applied to the cost of care. In addition, if a child has earnings, a \$65 month allowance from earned income only is allowed for personal needs. The personal needs funds can be held by the child, by the facility for the child's use, or by the child's family.

 Iowa Department of Human Services	CHAPTER SUBJECT: COVERAGE AND LIMITATIONS PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE
		E - 23 <hr/> DATE November 1, 1999

B. Personal Needs Funds

Each foster care child who is in a PMIC and who has income assigned to the Department receives a state warrant for the child's personal needs. This represents the monthly personal allowance the child keeps from the child's unearned income or child support received from the parent.

Some children may have earned income that is to be used for personal needs. When children have income sent directly to them, the child is also allowed a personal needs allowance.

Determine whether the child can manage his or her own funds or whether the facility must handle the funds. Make this decision part of the child's case plan. Facilities do not have the option of refusing to handle a resident's personal allowance funds if necessary and staff deem it appropriate. However, families may elect to handle their children's funds if they wish.

If the facility handles the funds, the facility must account for the funds. Purchase a surety bond or provide self-insurance to ensure the security of all personal funds of residents deposited with the facility.

Establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

Maintain two types of accounts to handle resident personal allowance funds:

- ◆ A small "use" account to secure the first \$50.00 of each resident's personal allowance funds. This can be a petty cash fund or a non-interest-bearing checking account.
- ◆ A larger interest-bearing checking account to handle all funds in excess of \$50.00 for each resident. This may be a single joint account separate from any of the facility's operating accounts, an individual account for each resident, or a pooled account of all residents funds.



The main function of the larger checking account is to act as a depository to generate interest and retain funds that later will be placed in the petty cash fund. If a single joint account is maintained, interest earned must be prorated periodically, normally upon receipt of the monthly bank statement, and credited to a separate ledger card for each resident.

If an individual checking account is opened for each resident, interest earned is automatically credited to each respective account. With this method, a second set of ledger cards is not necessary, as the individual check book register serves as a ledger card to record deposits and withdrawals.

Deposit all monthly personal allowance funds received into the larger account before being placed in the petty cash fund for resident use. Under no circumstances should the monthly deposits be made directly into the petty cash fund.

Then deposit the first \$50.00 of each resident's funds, or entire total if less than \$50.00, into a petty cash fund that consists solely of residents' funds. Set up a new individual ledger card for each resident that reflects the initial \$50.00 deposit into the petty cash fund. The individual financial record must be available on request to the resident or the resident's legal representatives.

Keep receipts for large purchases and vouchers for smaller items in individual envelopes for each resident in the petty cash fund box. The receipts or vouchers must indicate the resident's name, date, amount, and items purchased. Whenever possible, the resident should sign a voucher for all cash received from the petty cash fund, regardless of its intended use. This is an adequate receipt for that type of withdrawal.

The total cash on hand plus vouchers should equal the total of all ledger cards for the petty cash fund. The ledger and receipts for each resident must be made available for periodic audits by an accredited Department representative. The Department's representative must make an audit certification at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

Make all purchases other than large items through the petty cash fund. Make large purchases directly through the individual checking account only.



When a resident's account balance gets low in the petty cash fund, post the voucher to the ledger cards. As the petty cash fund amount for a resident is used, draw an amount to replenish the fund to \$50.00 from the larger account and place it into the petty cash fund.

Notify each resident who receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person. Notify the resident's social worker that the resident may lose eligibility for Medicaid or for SSI if the amount of the account, in addition to the resident's other nonexempt resources, reaches the SSI resource limit for one person.

C. Reserve Bed Days

Reserve bed payment is not available until the child has been physically admitted to the facility. The reserve bed days are paid to the facility when the child is absent at the time of nightly census.

1. Visits

For visit days to be payable, the absence must be in accordance with the following conditions:

- ◆ For foster care children, the visits must be coordinated with the child's DHS social worker.
- ◆ The visits must be consistent with the child's case permanency plan and the facility's individual case plan.
- ◆ The intent of the Department and the facility must be for the child to return to the facility after the visitation.
- ◆ Staff from the psychiatric medical institution must be available to provide support to the child and family during the visit.
- ◆ Payment for reserve bed days cannot exceed 14 consecutive days or 30 days per year except upon written approval of a DHS regional administrator. In no case must payment exceed 60 days per year.



Payment for reserve days must be canceled and payment returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interests. In that case, payment must be canceled effective the day after the joint decision not to return the child.

Payment for reserve bed days must be canceled effective the day after a decision is made not to return the child by the court or, in voluntary placement, by the parent.

Upon return to the facility, IFMC review is required if the child's absence from the facility is greater than 30 consecutive days. If the IFMC determines the child's care in the facility is no longer appropriate, then Medicaid payment is discontinued.

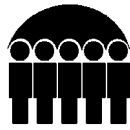
2. Hospital Leaves

Reserve bed payment must be made for days a resident is absent from a PMIC and hospitalized in an acute care general hospital. The reserve bed day payments do not apply for an absence or transfer of a child to a sub-acute unit of the PMIC.

The following policies apply to all Medicaid-eligible residents:

- ◆ Payment will not be authorized for over ten days per calendar month and will not be authorized for over ten days for any continuous stay.
- ◆ IFMC review is required when the child returns to the facility after a 10-day absence.

Payment for reserve bed days must be canceled and payment returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interest. In that case, payment must be canceled effective the day after the joint decision not to return the child.



3. Other Absences for Foster Children

Reserve bed payment must be made for days a foster care child is absent from a PMIC at the time of a nightly census for such reasons as detention, shelter care, or running away. The absence must be in accordance with the following policies:

- ◆ The facility must notify the Department social worker within 24 hours after the child is out of the facility for running away or other unplanned reason.
- ◆ The intent of the Department and the facility must be for the child to return to the facility after the absence.
- ◆ Payment for reserve bed days for other absences must not exceed 14 consecutive days or 30 days per year, except upon written approval of the Department's area administrator. In no case must payment exceed 60 days per year.

Payment for reserve bed days must be canceled and payments returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interests. In that case, payment must be canceled effective the day after the joint decision not to return the child.

Payment for reserve bed days must be canceled effective the day after a decision is made by the court or by the parent, in a voluntary placement not to return the child to the facility.

Obtain IFMC review before the child's return to the facility if the child is away for 14 or more consecutive days. If the IFMC determines the child's care in the facility is no longer appropriate, then Medicaid payment is discontinued.

V. BASIS OF PAYMENT FOR OUTPATIENT SERVICES

Outpatient day treatment services are paid on a fixed-fee basis. Bill for day treatment in one-hour units, using code W0584.



I. INSTRUCTIONS AND CLAIM FORM

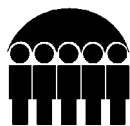
A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the UB-92 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	PROVIDER'S NAME, ADDRESS & TELEPHONE NUMBER	OPTIONAL – Enter the complete name, address, and phone number of the billing facility or service supplier.
2.	PAYER CONTROL NUMBER	LEAVE BLANK.
3.	PATIENT CONTROL NUMBER	OPTIONAL – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
4.	TYPE OF BILL	REQUIRED* – Enter a three-digit number consisting of one digit from each of the following categories in this sequence: First digit Type of facility Second digit Bill classification Third digit Frequency



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 2

DATE

September 1, 1998

		<u>Type of Facility</u> 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice <u>Bill Classification</u> 1 Inpatient hospital, inpatient SNF or hospice (nonhospital based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient SNF or hospice (hospital based) 4 Hospital referenced laboratory services, home health agency, rehabilitation agency <u>Frequency</u> 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
5.	FEDERAL TAX NUMBER	OPTIONAL – No entry required.
6.	STATEMENT COVERS PERIOD	REQUIRED – Enter the month, day, and year under both the From and To categories for the period.
7.	COVERED DAYS	REQUIRED FOR INPATIENT* – <u>Inpatient, PMIC, and SNF</u> – Enter the number of covered days. Do not use the day of discharge in your calculations. <u>Rehabilitation Agency</u> – Enter the number of days the patient was seen in this billing period. The number of days is used to determine copayment liability. <u>Hospice Services and Home Health Agencies</u> – Leave blank.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT
PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

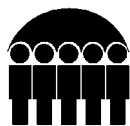
CHAPTER PAGE

F - 3

DATE

September 1, 1998

8.	NONCOVERED DAYS	REQUIRED FOR INPATIENT, WHERE APPLICABLE* – <u>Inpatient, PMIC, and SNF</u> – Enter the number of non-covered days, if applicable. Do not use the day of discharge in your calculations. <u>Hospice Services, Rehabilitation, and Home Health Agencies</u> – Leave blank.
9.	COINSURANCE DAYS	OPTIONAL – No entry required.
10.	LIFETIME RESERVE DAYS	OPTIONAL – No entry required.
11.	UNLABELED FIELD	OPTIONAL – No entry required.
12.	PATIENT NAME	REQUIRED – Enter the last name, first name, and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
13.	PATIENT ADDRESS	OPTIONAL* – Enter the full address of the recipient.
14.	PATIENT BIRTHDATE	OPTIONAL – Enter the recipient's birthdate as month, day, and year. Completing this field may expedite processing of your claim.
15.	PATIENT SEX	REQUIRED – Enter the patient's sex.
16.	PATIENT MARITAL STATUS	OPTIONAL – No entry required.
17.	ADMISSION DATE	REQUIRED* – <u>Inpatient, PMIC, and SNF</u> – Enter the date of admission for inpatient services. <u>Outpatient</u> – Enter the dates of service. <u>Home Health Agency and Hospice</u> – Enter the date of admission for care. <u>Rehabilitation Agency</u> – No entry required.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

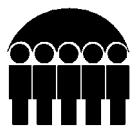
CHAPTER PAGE

F - 4

DATE

September 1, 1998

18.	ADMISSION HOUR	<p>REQUIRED FOR INPATIENT/PMIC/SNF – The following chart consists of possible admission times and a corresponding code. Enter the code that corresponds to the hour patient was admitted for inpatient care.</p> <table><tr><th><u>Code</u></th><th><u>Time - AM</u></th><th><u>Code</u></th><th><u>Time - PM</u></th></tr><tr><td>00</td><td>12:00 - 12:59 Midnight</td><td>12</td><td>12:00 - 12:59 Noon</td></tr><tr><td>01</td><td>1:00 - 1:59</td><td>13</td><td>1:00 - 1:59</td></tr><tr><td>02</td><td>2:00 - 2:59</td><td>14</td><td>2:00 - 2:59</td></tr><tr><td>03</td><td>3:00 - 3:59</td><td>15</td><td>3:00 - 3:59</td></tr><tr><td>04</td><td>4:00 - 4:59</td><td>16</td><td>4:00 - 4:59</td></tr><tr><td>05</td><td>5:00 - 5:59</td><td>17</td><td>5:00 - 5:59</td></tr><tr><td>06</td><td>6:00 - 6:59</td><td>18</td><td>6:00 - 6:59</td></tr><tr><td>07</td><td>7:00 - 7:59</td><td>19</td><td>7:00 - 7:59</td></tr><tr><td>08</td><td>8:00 - 8:59</td><td>20</td><td>8:00 - 8:59</td></tr><tr><td>09</td><td>9:00 - 9:59</td><td>21</td><td>9:00 - 9:59</td></tr><tr><td>10</td><td>10:00 - 10:59</td><td>22</td><td>10:00 - 10:59</td></tr><tr><td>11</td><td>11:00 - 11:59</td><td>23</td><td>11:00 - 11:59</td></tr><tr><td></td><td></td><td>99</td><td>Hour unknown</td></tr></table>	<u>Code</u>	<u>Time - AM</u>	<u>Code</u>	<u>Time - PM</u>	00	12:00 - 12:59 Midnight	12	12:00 - 12:59 Noon	01	1:00 - 1:59	13	1:00 - 1:59	02	2:00 - 2:59	14	2:00 - 2:59	03	3:00 - 3:59	15	3:00 - 3:59	04	4:00 - 4:59	16	4:00 - 4:59	05	5:00 - 5:59	17	5:00 - 5:59	06	6:00 - 6:59	18	6:00 - 6:59	07	7:00 - 7:59	19	7:00 - 7:59	08	8:00 - 8:59	20	8:00 - 8:59	09	9:00 - 9:59	21	9:00 - 9:59	10	10:00 - 10:59	22	10:00 - 10:59	11	11:00 - 11:59	23	11:00 - 11:59			99	Hour unknown
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19.	TYPE OF ADMISSION	<p>REQUIRED FOR INPATIENT/PMIC/SNF – Enter the code corresponding to the priority level of this inpatient admission.</p> <table><tr><td>1</td><td>Emergency</td></tr><tr><td>2</td><td>Urgent</td></tr><tr><td>3</td><td>Elective</td></tr><tr><td>4</td><td>Newborn</td></tr><tr><td>9</td><td>Information unavailable</td></tr></table>	1	Emergency	2	Urgent	3	Elective	4	Newborn	9	Information unavailable																																														
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2	Urgent																																																									
3	Elective																																																									
4	Newborn																																																									
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20.	SOURCE OF ADMISSION	<p>REQUIRED FOR INPATIENT/PMIC/SNF – Enter the code that corresponds to the source of this admission.</p> <table><tr><td>1</td><td>Physician referral</td></tr><tr><td>2</td><td>Clinic referral</td></tr><tr><td>3</td><td>HMO referral</td></tr><tr><td>4</td><td>Transfer from a hospital</td></tr><tr><td>5</td><td>Transfer from a skilled nursing facility</td></tr><tr><td>6</td><td>Transfer from another health care facility</td></tr><tr><td>7</td><td>Emergency room</td></tr><tr><td>8</td><td>Court/law enforcement</td></tr><tr><td>9</td><td>Information unavailable</td></tr></table>	1	Physician referral	2	Clinic referral	3	HMO referral	4	Transfer from a hospital	5	Transfer from a skilled nursing facility	6	Transfer from another health care facility	7	Emergency room	8	Court/law enforcement	9	Information unavailable																																						
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Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

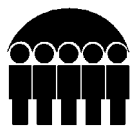
CHAPTER PAGE

F - 5

DATE

September 1, 1998

21.	DISCHARGE HOUR	<p>REQUIRED FOR INPATIENT/PMIC/SNF – The following chart consists of possible discharge times and a corresponding code. Enter the code that corresponds to the hour patient was discharged from inpatient care.</p> <p>See Field 18, Admission Hour, for instructions for accepted discharge hour codes.</p>
22.	PATIENT STATUS	<p>REQUIRED FOR INPATIENT/PMIC/SNF – Enter the code that corresponds to the status of the patient at the end of service.</p> <ul style="list-style-type: none">01 Discharged to home or self care (routine discharge)02 Discharged/transferred to other short-term general hospital for inpatient care03 Discharged/transferred to a skilled nursing facility (SNF)04 Discharged/transferred to an intermediate care facility (ICF)05 Discharged/transferred to another type of institution for inpatient care or outpatient services06 Discharged/transferred to home with care of organized home health services07 Left care against medical advice or otherwise discontinued own care08 Discharged/transferred to home with care of home IV provider10 Discharged/transferred to mental health care11 Discharged/transferred to Medicaid certified rehabilitation unit12 Discharged/transferred to Medicaid certified substance abuse unit13 Discharged/transferred to Medicaid certified psychiatric unit20 Expired30 Remains a patient or is expected to return for outpatient services (valid only for nonDRG claims)



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT
PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

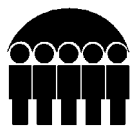
CHAPTER PAGE

F - 6

DATE

September 1, 1998

23.	MEDICAL/ HEALTH RECORD NUMBER	OPTIONAL – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
24. – 30.	CONDITION CODES	<p>CONDITIONAL* – Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below.</p> <p>Up to seven codes may be used to describe the conditions surrounding a patient's treatment.</p> <p><u>General</u></p> <p>01 Military service related 02 Condition is employment related 03 Patient covered by an insurance not reflected here 04 HMO enrollee 05 Lien has been filed</p> <p><u>Inpatient Only</u></p> <p>80 Neonatal level II or III unit 81 Physical rehabilitation unit 82 Substance abuse unit 83 Psychiatric unit X3 IFMC approved lower level of care, ICF X4 IFMC approved lower level of care, SNF 91 Respite care</p> <p><u>Outpatient Only</u></p> <p>84 Cardiac rehabilitation program 85 Eating disorder program 86 Mental health program 87 Substance abuse program 88 Pain management program 89 Diabetic education program 90 Pulmonary rehabilitation program 98 Pregnancy indicator – outpatient or rehabilitation agency</p>



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT
PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

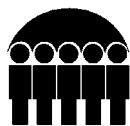
CHAPTER PAGE

F - 7

DATE

September 1, 1998

		<u>Special Program Indicator</u> A1 EPSDT A2 Physically handicapped children's program A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery <u>Home Health Agency</u> (Medicare not applicable) XA Condition stable XB Not homebound XC Maintenance care XD No skilled service
31.	UNLABELED FIELD	OPTIONAL – No entry required.
32. – 35. A. & B.	OCCURRENCE CODES AND DATES	REQUIRED IF APPLICABLE* – If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence. <u>Accident Related</u> 01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

**BILLING AND PAYMENT
PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN**

CHAPTER PAGE

F - 8

DATE

September 1, 1998

		<u>Insurance Related</u> 17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted <u>Other</u> 11 Date of onset
36. A. & B.	OCCURRENCE SPAN CODES AND DATES	OPTIONAL – No entry required.
37. A. – C.	TRANSACTION CONTROL NUMBER	LEAVE BLANK.
38.	RESPONSIBLE PARTY NAME AND ADDRESS	OPTIONAL – No entry required.
39. – 41. a. – d.	VALID CODES AND AMOUNTS	OPTIONAL – No entry required.
42.	REVENUE CODE	REQUIRED – Enter the appropriate corresponding revenue code for each item or service billed. Replace the “X” with a subcategory code, where appropriate, to clarify the code. Please note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call Provider Relations at 1-800-338-7909 or 515-327-5120 (in Des Moines).



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

**PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN**

CHAPTER PAGE

F - 9

DATE

September 1, 1998

**11X Room & Board – Private
(medical or general)**
Routine service charges for single bed rooms.

Subcategories

- 0 General classifications
- 1 Medical/surgical/GYN
- 2 OB
- 3 Pediatric
- 4 Psychiatric
- 6 Detoxification
- 7 Oncology
- 8 Rehabilitation
- 9 Other

**12X Room & Board – Semi-Private Two Bed
(medical or general)**
Routine service charges incurred for
accommodations with two beds.

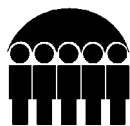
Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

**13X Room & Board – Semi-Private Three and Four
Beds (medical or general)**
Routine service charges incurred for
accommodations with three and four beds.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 10

DATE

September 1, 1998

14X Private (deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

15X Room & Board – Ward (medical or general)

Routine service charge for accommodations with five or more beds.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other

16X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategories

- 0 General classifications
- 4 Sterile environment
- 7 Self care
- 9 Other



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 11

DATE

September 1, 1998

17X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Subcategories

- 0 General classification
- 1 Newborn
- 2 Premature
- 5 Neonatal ICU
- 9 Other

18X Leave of Absence

Charges for holding a room or bed for a patient while the patient is temporarily away from the provider.

Subcategory

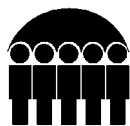
- 5 Nursing home (for hospitalization)

20X Intensive Care

Routine service for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategories

- 0 General classification
- 1 Surgical
- 2 Medical
- 3 Pediatric
- 4 Psychiatric
- 6 Post ICU
- 7 Burn care
- 8 Trauma
- 9 Other intensive care



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 12

DATE

September 1, 1998

21X Coronary Care

Routine service charge for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit.

Subcategories

- 0 General classification
- 1 Myocardial infarction
- 2 Pulmonary care
- 3 Heart transplant
- 4 Post CCU
- 9 Other coronary care

22X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

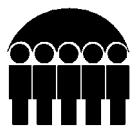
Subcategories

- 0 General classification
- 1 Admission charge
- 2 Technical support charge
- 3 U.R. service charge
- 4 Late discharge, medically necessary
- 9 Other special charges

23X Incremental Nursing Charge Rate

Subcategories

- 0 General classification
- 1 Nursery
- 2 OB
- 3 ICU
- 4 CCU
- 9 Other



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 13

DATE

September 1, 1998

24X All Inclusive Ancillary

A flat rate charge incurred on either a daily or total stay basis for ancillary services only.

Subcategories

- 0 General classification
- 9 Other inclusive ancillary

25X Pharmacy

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies.

Subcategories

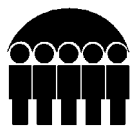
- 0 General classification
- 1 Generic drugs
- 2 Nongeneric drugs
- 3 Take home drugs
- 4 Drugs incident to other diagnostic services
- 5 Drugs incident to radiology
- 6 Experimental drugs
- 7 Nonprescription
- 8 IV solutions
- 9 Other pharmacy

26X IV Therapy

Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategories

- 0 General classification
- 1 Infusion pump
- 2 IV therapy/pharmacy services
- 3 IV therapy/drug/supply delivery
- 4 IV therapy/supplies
- 9 Other IV therapy



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

**PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN**

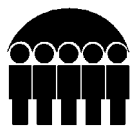
CHAPTER PAGE

F - 14

DATE

September 1, 1998

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| | | <p>27X Medical/Surgical Supplies and Devices
(also see 62X, an extension of 27X)
Charges for supply items required for patient care.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Nonsterile supply2 Sterile supply3 Take home supplies4 Prosthetic/orthotic devices5 Pacemaker6 Intraocular lens7 Oxygen – take home8 Other implants9 Other supplies/devices <p>28X Oncology
Charges for the treatment of tumors and related diseases.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification9 Other oncology <p>29X Durable Medical Equipment
(other than renal)
Charges for medical equipment that can withstand repeated use (excluding renal equipment).</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Rental2 Purchase of new DME3 Purchase of used DME4 Supplies/drugs for DME effectiveness
(home health agency only)9 Other equipment |
|--|--|---|



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 15

DATE

September 1, 1998

30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-92 form field number 44.

Subcategories

- 0 General classification
- 1 Chemistry
- 2 Immunology
- 3 Renal patient (home)
- 4 Nonroutine dialysis
- 5 Hematology
- 6 Bacteriology and microbiology
- 9 Other laboratory

31X Laboratory – Pathological

Charges for diagnostic and routine laboratory tests on tissues and cultures.

For outpatient services, indicate the CPT code for each lab charge in UB-92 form field number 44.

Subcategories

- 0 General classification
- 1 Cytology
- 2 Histology
- 4 Biopsy
- 9 Other

32X Radiology – Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting of radiographs and fluorographs.

Subcategories

- 0 General classification
- 1 Angiocardiology
- 2 Arthrography
- 3 Arteriography
- 4 Chest x-ray
- 9 Other



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 16

DATE

September 1, 1998

33X Radiology – Therapeutic

Charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategories

- 0 General classification
- 1 Chemotherapy – injected
- 2 Chemotherapy – oral
- 3 Radiation therapy
- 5 Chemotherapy – IV
- 9 Other

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Subcategories

- 0 General classification
- 1 Diagnostic
- 2 Therapeutic
- 9 Other

35X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Subcategories

- 0 General classification
- 1 Head scan
- 2 Body scan
- 9 Other CT scans



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 17

DATE

September 1, 1998

36X Operating Room Services

Charges for services provided to patients by those specifically trained nursing personnel providing assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Subcategories

- 0 General classification
- 1 Minor surgery
- 2 Organ transplant – other than kidney
- 7 Kidney transplant
- 9 Other operating room services

37X Anesthesia

Charges for anesthesia services in the hospital.

Subcategories

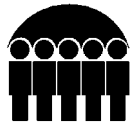
- 0 General classification
- 1 Anesthesia incident to radiology
- 2 Anesthesia incident to other diagnostic services
- 4 Acupuncture
- 9 Other anesthesia

38X Blood

Charges for blood must be separately identified for private payer purposes.

Subcategories

- 0 General classification
- 1 Packed red cells
- 2 Whole blood
- 3 Plasma
- 4 Platelets
- 5 Leukocytes
- 6 Other components
- 7 Other derivatives (cryoprecipitates)
- 9 Other blood



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 18

DATE

September 1, 1998

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategories

- 0 General classification
- 1 Blood administration
- 9 Other blood storage and processing

40X Other Imaging Services

Subcategories

- 0 General classification
- 1 Diagnostic mammography
- 2 Ultrasound
- 3 Screening mammography
- 4 Positron emission tomography
- 9 Other imaging services

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure. Charges for other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Subcategories

- 0 General classification
- 1 Inhalation services
- 3 Hyperbaric oxygen therapy
- 9 Other respiratory services



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 19

DATE

September 1, 1998

42X Physical Therapy

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other occupational therapy/trial occupational therapy – rehab agency

43X Occupational Therapy

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategories

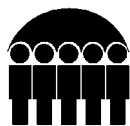
- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other occupational therapy/trial occupational therapy – rehab agency

44X Speech – Language Pathology

Charges for services provided to those with impaired functional communication skills.

Subcategories

- 0 General classification
- 1 Visit charge
- 2 Hourly charge
- 3 Group rate
- 4 Evaluation or reevaluation
- 9 Other speech-language pathology/trial speech therapy – rehab agency



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 20

DATE

September 1, 1998

45X Emergency Room

Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care.

Subcategories

- 0 General classification
- 9 Other emergency room

46X Pulmonary Function

Charges for tests measuring inhaled and exhaled gases. Charges for the analysis of blood and for tests evaluating the patient's ability to exchange oxygen and other gases.

Subcategories

- 0 General classification
- 9 Other pulmonary function

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Subcategories

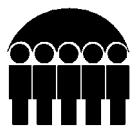
- 0 General classification
- 1 Diagnosis
- 2 Treatment
- 9 Other audiology

48X Cardiology

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests.

Subcategories

- 0 General classification
- 1 Cardiac cath lab
- 2 Stress test
- 9 Other cardiology



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

**PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN**

CHAPTER PAGE

F - 21

DATE

September 1, 1998

49X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by other categories.

Subcategories

- 0 General classification
- 9 Other ambulatory surgical care

50X Outpatient Services

Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service.

Subcategories

- 0 General classification
- 9 Other outpatient services

51X Clinic

Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

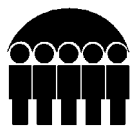
Subcategories

- 0 General classification
- 1 Chronic pain center
- 2 Dental clinic
- 3 Psychiatric clinic
- 4 OB-GYN clinic
- 5 Pediatric clinic
- 9 Other clinic

52X Free-Standing Clinic

Subcategories

- 0 General classification
- 1 Rural health – clinic
- 2 Rural health – home
- 3 Family practice
- 9 Other free-standing clinic



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 22

DATE

September 1, 1998

53X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Subcategories

- 0 General classification
- 1 Osteopathic therapy
- 9 Other osteopathic services

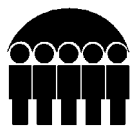
54X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention.

Note: Ambulance is payable on the UB-92 form **only** in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis/documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility.

Subcategories

- 0 General classification
- 1 Supplies
- 2 Medical transport
- 3 Heart mobile
- 4 Oxygen
- 5 Air ambulance
- 6 Neonatal ambulance services
- 7 Pharmacy
- 8 Telephone transmission EKG
- 9 Other ambulance



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

**PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN**

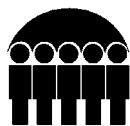
CHAPTER PAGE

F - 23

DATE

September 1, 1998

- | | | | |
|--|--|--|--|
| | | | <p>55X Skilled Nursing (home health agency only)
Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Visit charge2 Hourly charge9 Other skilled nursing |
| | | | <p>56X Medical Social Services (home health agency only)
Charges for services such as counseling patients, interviewing and interpreting problems of social situations provided to patients on any basis.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Visit charge2 Hourly charge9 Other medical social services |
| | | | <p>57X Home Health Aide (home health agency only)
Charges made by a home health agency for personnel primarily responsible for the personal care of the patient.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Visit charge2 Hourly charge9 Other home health aide services |
| | | | <p>61X MRI
Charges for Magnetic Resonance Imaging of the brain and other body parts.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Brain (including brainstem)2 Spinal cord (including spine)9 Other MRI |



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 24

DATE

September 1, 1998

- | | | |
|--|--|---|
| | | <p>62X Medical/Surgical Supplies (extension of 27X)
Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">1 Supplies incident to radiology2 Supplies incident to other diagnostic services <p>63X Drugs Requiring Specific Identification
Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in UB-92 form field number 44.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Single source drug2 Multiple source drug3 Restrictive prescription4 Erythropoietin (EPO), less than 10,000 units5 Erythropoietin (EPO), 10,000 or more units6 Drugs requiring detailed coding <p>64X Home IV Therapy Services
Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy.</p> <p><u>Subcategories</u></p> <ul style="list-style-type: none">0 General classification1 Nonroutine nursing, central line2 IV site care, central line3 IV site/change, peripheral line4 Nonroutine nursing, peripheral line5 Training patient/caregiver, central line6 Training, disabled patient, central line7 Training, patient/caregiver, peripheral line8 Training, disabled patient, peripheral line9 Other IV therapy services |
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65X Hospice Services (hospice only)

Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition.

Subcategories

- 1 Routine home care
- 2 Continuous home care (hourly)
- 5 Inpatient respite care
- 6 General inpatient care
- 8 Care in an ICF or SNF

70X Cast Room

Charges for services related to the application, maintenance, and removal of casts.

Subcategories

- 0 General classification
- 9 Other cast room

71X Recovery Room

Subcategories

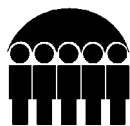
- 0 General classification
- 9 Other recovery room

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite.

Subcategories

- 0 General classification
- 1 Labor
- 2 Delivery
- 3 Circumcision
- 4 Birthing center
- 9 Other labor room/delivery



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 26

DATE

September 1, 1998

73X EKG/ECG (electro-cardiogram)

Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments.

Subcategories

- 0 General classification
- 1 Holter monitor
- 2 Telemetry
- 9 Other EKG/ECG

74X EEG (electro-encephalogram)

Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders.

Subcategories

- 0 General classification
- 9 Other EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategories

- 0 General classification
- 9 Other gastro-intestinal

76X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes (one unit per hour) on outpatient claims.

Subcategories

- 0 General classification
- 1 Treatment room
- 2 Observation room
- 9 Other treatment/observation room



79X Lithotripsy

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategories

- 0 General classification
- 9 Other lithotripsy

80X Inpatient Renal Dialysis

A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Subcategories

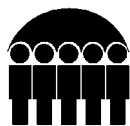
- 0 General classification
- 1 Inpatient hemodialysis
- 2 Inpatient peritoneal (nonCAPD)
- 3 Inpatient continuous ambulatory peritoneal dialysis
- 4 Inpatient continuous cycling peritoneal dialysis (CCPD)
- 9 Other inpatient dialysis

81X Organ Acquisition (see 89X)

The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.)

Subcategories

- 0 General classification
- 1 Living donor – kidney
- 2 Cadaver donor – kidney
- 3 Unknown donor – kidney
- 4 Other kidney acquisition
- 5 Cadaver donor – heart
- 6 Other heart acquisition
- 7 Donor – liver
- 9 Other organ acquisition



82X Hemodialysis – Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategories

- 0 General classification
- 1 Hemodialysis/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient hemodialysis

83X Peritoneal Dialysis – Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategories

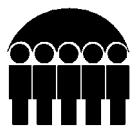
- 0 General classification
- 1 Peritoneal/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient peritoneal dialysis

84X Continuous Ambulatory Peritoneal Dialysis (CCPD) – Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer.

Subcategories

- 0 General classification
- 1 CAPD/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient CAPD



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 29

DATE

September 1, 1998

85X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night.

Subcategories

- 0 General classification
- 1 CCPD/composite or other rate
- 2 Home supplies
- 3 Home equipment
- 4 Maintenance/100%
- 5 Support services
- 9 Other outpatient CCPD

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Subcategories

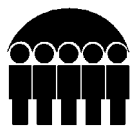
- 0 General classification
- 1 Ultrafiltration
- 2 Home dialysis aid visit
- 9 Miscellaneous dialysis other

89X Other Donor Bank (extension of 81X)

Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see 81X).

Subcategories

- 0 General classification
- 1 Bone
- 2 Organ (other than kidney)
- 3 Skin
- 9 Other donor bank



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 30

DATE

September 1, 1998

92X Other Diagnostic Services

Subcategories

- 0 General classification
- 1 Peripheral vascular lab
- 2 Electromyelogram
- 3 Pap smear
- 4 Allergy test
- 5 Pregnancy test
- 9 Other diagnostic services

94X Other Therapeutic Services

Charges for other therapeutic services not otherwise categorized.

Subcategories

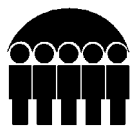
- 0 General classification
- 1 Recreational therapy
- 2 Education/training
- 3 Cardiac rehabilitation
- 4 Drug rehabilitation
- 5 Alcohol rehabilitation
- 6 Complex medical equipment – routine
- 7 Complex medical equipment – ancillary
- 9 Other therapeutic services

99X Patient Convenience Items

Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered.

Subcategories

- 0 General classification
- 1 Cafeteria/guest tray
- 2 Private linen service
- 3 Telephone/telegraph
- 4 TV/radio
- 5 Nonpatient room rentals
- 6 Late discharge charge
- 7 Admission kits
- 8 Beauty shop/barber
- 9 Other patient convenience items



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT
PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

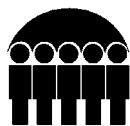
CHAPTER PAGE

F - 31

DATE

September 1, 1998

43.	REVENUE DESCRIPTION	OPTIONAL – Enter a description of each revenue code billed.
44.	HCPCS/CPT/ RATES	CONDITIONAL* – <u>Outpatient Hospital</u> – Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG. <u>Inpatient SNF</u> – Enter the HCPCS code W0511 for ventilator dependent patients, otherwise leave blank. <u>Home Health Agencies</u> – Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT related services. <u>All Others</u> – Leave blank.
45.	SERVICE DATE	OPTIONAL – Entry in this field is optional for outpatient and no entry required for all others.
46.	UNITS OF SERVICE	REQUIRED – <u>Inpatient</u> – Enter the appropriate units of service for accommodation days. <u>Outpatient</u> – Enter the appropriate units of service provided per CPT/revenue code. (Batch-bill APGs require one unit = 15 minutes of service time.) <u>Home Health Agencies</u> – Enter the appropriate units for each service billed. A unit of service = a visit. Prior authorization private duty nursing/personal care – one unit = an hour.
47.	TOTAL CHARGES	REQUIRED – Enter the total charges for each code billed.
48.	NONCOVERED CHARGES	REQUIRED – Enter the noncovered charges for each applicable code.
49.	UNLABELED FIELD	OPTIONAL – No entry required.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 32

DATE

September 1, 1998

50. A. – C.	PAYER IDENTIFICATION	REQUIRED – Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.
51.	PROVIDER NUMBER	REQUIRED – Enter your seven-digit Medicaid provider number.
52. A. – C.	RELEASE OF INFORMATION CERTIFICATION INDICATOR	OPTIONAL – No entry required.
53. A. – C.	ASSIGNMENT OF BENEFITS...	OPTIONAL – No entry required.
54. A. – C.	PRIOR PAYMENTS	REQUIRED – If applicable, enter the amount paid by third-party payer. Do not enter previous Medicaid payments.
55. A. – C.	ESTIMATED AMOUNT DUE	OPTIONAL – No entry required.
56. – 57.	UNLABELED FIELDS	OPTIONAL – No entry required.
58. A. – C.	INSURED'S NAME	REQUIRED – Enter the Medicaid recipient's last name, first name, and middle initial. Verify this information on the <i>Medical Assistance Eligibility Card</i> .
59. A. – C.	PATIENT'S RELATIONSHIP TO INSURED	OPTIONAL – No entry required.
60. A. – C.	CERTIFICATE/ SOCIAL SECURITY NUMBER/HEALTH INSURANCE CLAIM/IDENTI- FICATION	REQUIRED* – Enter the patient's Medicaid identification number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

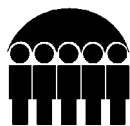
CHAPTER PAGE

F - 33

DATE

September 1, 1998

61. A. – C.	INSURED GROUP NAME	OPTIONAL* – No entry required.
62.	INSURANCE GROUP NUMBER	OPTIONAL* – No entry required.
63.	TREATMENT AUTHORIZATION CODE	CONDITIONAL – If the patient is a MediPASS patient and the service is not an emergency, the physician authorization number must be shown here.
64. – 66.	EMPLOYMENT STATUS, EMPLOYER NAME AND LOCATION	OPTIONAL* – No entry required.
67.	PRINCIPAL DIAGNOSIS CODE	REQUIRED – Enter the ICD-9-CM code for the principal diagnosis.
68. – 75.	OTHER DIAGNOSIS CODES	CONDITIONAL – Enter the ICD-9-CM codes for diagnosis, other than principal, for the additional diagnosis.
76.	ADMITTING DIAGNOSIS	OPTIONAL – No entry required.
77.	“E” CODE	OPTIONAL – No entry required.
78.	DRG ASSIGNMENT	OPTIONAL – No entry required.
79.	PROCEDURE CODING METHOD USED	OPTIONAL – No entry required.
80.	PRINCIPAL PROCEDURE AND DATE	CONDITIONAL – For the principal surgical procedure, enter the ICD-9-CM procedure code and surgery date, when applicable.
81.	OTHER PROCEDURE CODES AND DATES	CONDITIONAL – For additional surgical procedures, enter the ICD-9-CM procedure codes and dates.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN

CHAPTER PAGE

F - 34

DATE

September 1, 1998

82.	ATTENDING PHYSICIAN ID	<p>REQUIRED –</p> <p><u>Inpatient Hospital, SNF, Rehab Agency, Home Health Agency, and PMIC</u> – Enter the UPIN or seven-digit Iowa Medicaid provider number for the treating physician. The last name, first initial, and discipline are also needed. The treating physician has primary responsibility for the patient's care from the start of hospitalization.</p> <p><u>Outpatient</u> – Enter the UPIN or seven-digit Iowa Medicaid provider number of the physician referring the patient to the hospital. This area should not be completed if the primary physician did not give the referral. On outpatient billings, do not show treating physician information in this area.</p> <p>Note: For lock-in patients, enter the seven-digit Iowa Medicaid provider number of the lock-in physician or clinic in place of the above.</p>
83.	OTHER PHYSICIAN ID	<p>OPTIONAL – Enter the UPIN number of physician performing the principal procedure, if applicable. If a UPIN number is unavailable, enter the physician's seven-digit Iowa Medicaid provider number. The last name, first initial, and discipline are also needed.</p>
84.	REMARKS	<p>OPTIONAL – No entry required.</p>
85.	PROVIDER REPRESENTATIVE SIGNATURE	<p>REQUIRED – The signature of an authorized representative must be shown.</p> <p>If the signature consists of computer-generated block letters, the signature must be initialed. A signature stamp may be used.</p>
86.	DATE BILL SUBMITTED	<p>REQUIRED – Enter the original claim submission date. For resubmissions, be sure to indicate the original submission date, not the date of resubmission.</p>
BACK OF FORM	NOTE	<p>REQUIRED – The back of the claim form must be intact on every claim form submitted.</p>

1

2

3 PATIENT CONTROL NO.

4 TYPE
01 001

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD
FROM THROUGH

7 COVD.

8 N.C.D.

9 C.I.D.

10 L.R.D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

17 DATE

ADMISSION

18 HR

19 TYPE

20 SNO

21 D.H.R.

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES

31

32 CODE

OCCURRENCE DATE

33 CODE

OCCURRENCE DATE

34 CODE

OCCURRENCE DATE

35 CODE

OCCURRENCE DATE

36 CODE

OCCURRENCE SPAN

FROM

THROUGH

37

A

B

C

38 CODE

VALUE CODES

AMOUNT

39 CODE

VALUE CODES

AMOUNT

40 CODE

VALUE CODES

AMOUNT

a

b

c

d

42 REV. CD.

43 DESCRIPTION

44 HCPCS / RATES

45 SERV. DATE

46 SERV. UNITS

47 TOTAL CHARGES

48 NON-COVERED CHARGES

49

50 PAYER

51 PROVIDER NO.

52 REL

53 AGG

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

DUE FROM PATIENT ▶

58 INSURED'S NAME

59 P.REL.

60 CERT. - SSN - HIC - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.

68 CODE

69 CODE

70 CODE

71 CODE

72 CODE

73 CODE

74 CODE

75 CODE

76 CODE

77 CODE

78 CODE

79 ADM. DIAG. CD.

80 E-CODE

81

82 P.C.

83

PRINCIPAL PROCEDURE CODE

84

OTHER PROCEDURE CODE

85

OTHER PROCEDURE CODE

86

OTHER PROCEDURE CODE

87

OTHER PROCEDURE CODE

88

OTHER PROCEDURE CODE

89

OTHER PROCEDURE CODE

90

91 REMARKS

92 ATTENDING PHYS. ID

93 OTHER PHYS. ID

94 OTHER PHYS. ID

95 PROVIDER REPRESENTATIVE

96 DATE

X

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL:

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanatoriums, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

if the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.


I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

This is to certify that:

- (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;
- (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

 Iowa Department of Human Services	CHAPTER SUBJECT: BILLING AND PAYMENT PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER	PAGE
		DATE	F - 37 September 1, 1998

B. Facsimile of Claim Form, UB-92 (front and back)

(See the preceding pages.)

II. REMITTANCE ADVICE AND EXPLANATION

A. Remittance Advice Explanation


To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

 Iowa Department of Human Services	CHAPTER SUBJECT: BILLING AND PAYMENT PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE F - 38
		DATE September 1, 1998

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Outpatient and Inpatient Remittance Advice

(See the following pages.)

10: [REDACTED] 1. R.A. NO.: 0000026 2. 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [REDACTED] 4. PAGE: 5. 3

**** PATIENT NAME **** RECIP ID TRANS-CONTROL-NUMBER BILLED OTHER NON COV ALLOWED PAID BY MEDICAL
LINE SVC-DATE PROC APG UNITS AMT, SOURCES CHARGES CHARGE MCAID REC. NO. S EOB EOB

* 6. CLAIM TYPE: OUTPATIENT

* 7. CLAIM PAID

ORIGINAL CLAIMS:

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.											
5.	[REDACTED]	10.	70220	351	1	81.00	0.00	0.00	58.60	APG	[REDACTED]	17.	0	000	000												
18.	MED APG: 633	9.	4-96339-00-550-0899-00	212.45	11.	212.45	0.00	0.00	101.04	13.	0.00	14.	101.04	15.	0.00	16.	0001	000	000								
			FROM 11/18/96 TO 11/18/96														ER ADJ:										
			01 11/18/96 250	2	16.45	0.00	0.00	0.00										K	000	000							
			02 11/18/96 73510	351	1	81.00	0.00	0.00	0.00									K	000	000							
			03 11/18/96 99284	469	1	115.00	0.00	0.00	0.00										900	000							
			19.	4-96340-00-55	4-00	12.00	0.00	0.00	0.00	21.	0.00	0.00	10.96	22.	1.04				700	000							
			FROM 11/20/96 TO 11/20/96															ER ADJ									
			01 11/20/96 W9281	1	12.00	0.00	0.00	10.96											F	000	000						
			24.	00-551-0480	139.00	0.00	0.00	0.00	14.41	25.	0.00	0.00	124.59	26.	124.59				0001	000	000						
			23.	01 11/12/96 420	9	117.00	0.00	0.00	0.00	27.	0.00	0.00	0.00	28.	0.00	29.	0.00	30.	0.00	31.	NO PAYMENT	APG	32.	1	000	000	
			02 11/12/96 Q0086	054	1	22.00	0.00	0.00	14.41										BATCH	APG				33.	Z	000	000
			19.	4-96346-00-553-0487-00	131.90	0.00	0.00	0.00	0.00	21.	0.00	0.00	0.00	22.	46.03				001X	000	000						
			FROM 12/03/96 TO 12/03/96																ER ADJ:								
			01 12/03/96 80019	1	72.40	0.00	0.00	15.79												F	000	000					
			02 12/03/96 84478	1	20.00	0.00	0.00	8.17												F	000	000					
			03 12/03/96 84436	1	14.60	0.00	0.00	9.82												F	000	000					
			04 12/03/96 85027	1	18.40	0.00	0.00	9.25												F	000	000					
			05 12/03/96 00001	1	6.50	0.00	0.00	3.00												F	000	000					

REMITTANCE TOTALS

34.	NUMBER OF CLAIMS	PAID ORIGINAL CLAIMS:	PAID ADJUSTMENT CLAIMS:	DENIED ORIGINAL CLAIMS:	DENIED ADJUSTMENT CLAIMS:	PENDED CLAIMS (IN PROCESS):	AMOUNT OF CHECK:
	1	131.90	46.03	0.00	0.00	0.00	46.03
	0	0.00	0.00	0.00	0.00	0.00	0.00
	0	0.00	0.00	0.00	0.00	0.00	0.00
	0	0.00	0.00	0.00	0.00	0.00	0.00
	0	0.00	0.00	0.00	0.00	0.00	0.00

THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

35. 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 40 was intentionally left blank.

TO: [REDACTED] 2. R.A. NO.: 0000026 3. DATE PAID: 05/19/97 PROVIDER NUMBER: [REDACTED] PAGE: 1

PATIENT NAME RECIPIENT				COVERED PERIOD	ORG COVER	BILLED	OTHER	PAID BY	NON COV					
LAST	FIRST	M	ID NUM	TRANS-CONTROL-NUMBER	FROM	TO	CODE	DAYS	AMT.	INS.	MCAID	CHARGES	EOB	ECN

* (6) CLAIM TYPE: INPATIENT

• (7.) CLAIM STATUS: PAID

ORIGINAL: 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.

MEDICAL RECORD NUM: 399 4-96358-00-661-0066-00 12/12/96 12/12/96 384 1

ADJUSTMENT CLAIMS: 1095.65 0.00 673.61 0.00 900.00

SUBM/REIMB DIFF: 422.04

██████████ 4-96304-00-851-1010-00 09/07/96 09/12/96 316 5- 2053.00- 0.00 4751.30- 0.00
MEDICAL RECORD NUM: 393 ██████████ SUBM/REIMB DIFF: 2698.30

1.	DICAL RECORD NUM: 393	4-96304-00-851-2010-00 09/07/96 09/12/96 316	5	2452.30	0.00	4751.30	0.00
2.	ADJ-R: 20 TCN-TO-CREDIT: 9-62696-61-000-0175-00		NET	22. 399.30	0.00	2299.00-	0.00

4-96338-00-253-0021-00	08/16/96	08/19/96	0.00	736.00	0.00	0.00	0.00
------------------------	----------	----------	------	--------	------	------	------

REMITTANCE TOTALS

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	16	-----	7,669.89	2,674.80
PAID ADJUSTMENT CLAIMS: (23.)	NUMBER OF CLAIMS	2	-----	399.30	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF EFT DEPOSIT:			-----		2,674.80

---- THE FOLLOWING IS A DESCRIPTION OF THE ADJUSTMENT REASONS THAT APPEAR ABOVE:

20 CLM ERROR (24)


COUNT:

1

----- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:


25. 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 42 was intentionally left blank.


 Iowa Department of Human Services	CHAPTER SUBJECT:	CHAPTER	PAGE
	BILLING AND PAYMENT PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	F - 43 DATE September 1, 1998	

C. Outpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* number.
3. Date claim paid.
4. Billing provider's Medicaid (Title XIX) number.
5. *Remittance Advice* page number.
6. Type of claim used to bill Medicaid.
7. Status of following claims:
 - ◆ **Paid** – claims for which reimbursement is being made.
 - ◆ **Denied** – claims for which no reimbursement is being made.
 - ◆ **Suspended** – claims in process. These claims have not yet been paid or denied.
8. Recipient's last and first name.
9. Recipient's Medicaid (Title XIX) number.
10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Total charges submitted by provider.
12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
13. Total noncovered charges as they appear on claim.
14. Total charges allowed by Medicaid for service.

 Iowa Department of Human Services	CHAPTER SUBJECT: BILLING AND PAYMENT PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE F - 44
		DATE September 1, 1998

15. Total amount of Medicaid reimbursement as allowed for this claim.
16. Medical record number as assigned by provider; 10 characters are printable.
17. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.
18. Medical APG – assigned if payment is by medical APG.
19. Dates of service as reported on this claim.
20. Medical education add-on, if applicable.
21. Difference between submitted charge and reimbursement amount.
22. ER adjustment – indicates ER allowance was reduced.
23. Line item number.
24. The first date of service for the billed procedure.
25. The procedure code for the rendered service.
26. Line item procedure or ancillary APG.
27. The number of units of rendered service.
28. Charge submitted by provider for line item.
29. Amount applied to this line item from other resources, i.e., other insurance, spenddown.
30. Amount of noncovered charges for this line item.

 Iowa Department of Human Services	CHAPTER SUBJECT:	CHAPTER	PAGE
	BILLING AND PAYMENT PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	F - 45 DATE September 1, 1998	

31. Amount allowed by Medicaid for this line item.
32. Amount of Medicaid reimbursement as allowed for this line item.
33. Allowed charge source code:
 - 1** Level of care per diem
 - C** Percent of charges
 - F** Fee schedule
 - K** Denied
34. Remittance totals (found at the end of the *Remittance Advice*):
 - ◆ Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
 - ◆ Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
 - ◆ Number of denied original claims and amount billed by provider.
 - ◆ Number of denied adjusted claims and amount billed by provider.
 - ◆ Number of pended claims (in process) and amount billed by provider.
 - ◆ Amount of check.
35. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

D. Inpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* number.
3. Date claim paid.



Iowa
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Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

PSYCHIATRIC MEDICAL
INSTITUTIONS FOR CHILDREN


CHAPTER PAGE

F - 46

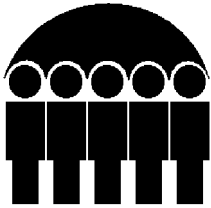
DATE

September 1, 1998

4. Billing provider's Medicaid (Title XIX) number.
5. *Remittance Advice* page number.
6. Type of claim used to bill Medicaid.
7. Status of following claims:
 - ♦ **Paid** – claims for which reimbursement is being made.
 - ♦ **Denied** – claims for which no reimbursement is being made.
 - ♦ **Suspended** – claims in process. These claims have not yet been paid or denied.
8. Recipient's last and first name.
9. Recipient's Medicaid (Title XIX) number.
10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Coverage dates as they appear on the claim.
12. DRG code.
13. Total number of covered days.
14. Total charges submitted by provider.
15. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
16. Total amount of Medicaid reimbursement as allowed for this claim.
17. Total noncovered charges as they appear on claim.

 Iowa Department of Human Services	CHAPTER SUBJECT: BILLING AND PAYMENT PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN	CHAPTER PAGE F - 47
		DATE September 1, 1998

18. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.
19. Medical record number as assigned by provider; 10 characters are printable.
20. Difference between submitted charge and reimbursement amount.
21. Adjusted claims and reason codes. Codes are explained at the end of the *Remittance Advice*.
22. Difference in submitted charge and reimbursement amount resulting in a credit to Medicaid.
23. Remittance totals (found at the end of the *Remittance Advice*):
 - ◆ Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
 - ◆ Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
 - ◆ Number of denied original claims and amount billed by provider.
 - ◆ Number of denied adjusted claims and amount billed by provider.
 - ◆ Number of pended claims (in process) and amount billed by provider.
 - ◆ Amount of check.
24. Description of individual adjustment reason codes.
25. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-82

Employees' Manual, Title 8
Medicaid Appendix

September 7, 1998

**PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN MANUAL
TRANSMITTAL NO. 98-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Psychiatric Medical Institutions for Children Manual*, Table of Contents (page 5), revised; Chapter E, *Coverage and Limitations*, page 29, reprinted; Chapter F, *Billing and Payment*, pages 1 through 20, revised; and pages 21 through 47, new.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

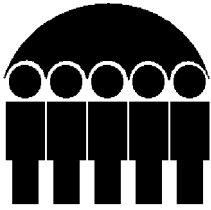
Material Superseded

Remove the following pages from the *Psychiatric Medical Institutions for Children Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 5)	March 1, 1996
Chapter F	
1, 2	August 1, 1995
3, 4	Undated
5-15	August 1, 1995
16-18	12/02/91
19, 20	March 1, 1992

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:
General Letter No. 8-AP-129
Employees' Manual, Title 8
Medicaid Appendix

October 29, 1999

**PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN MANUAL
TRANSMITTAL NO. 99-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Psychiatric Medical Institutions for Children Manual*, Table of Contents (pages 4 and 5), revised; and Chapter E, *Coverage and Limitations*, pages 1 through 27, revised.

Chapter E is revised to:

- Update *Coverage and Limitations* instructions the revisions update the accrediting and licensing bodies for psychiatric medical institutions for children (PMIC).
- Update the name of the fiscal agent.
- Update coverage group from ADC to Family Medical Assistance Program (FMAP).
- Clarify policy on reserve bed days for hospital leaves to reflect that it is not available for sub-acute units.

Date Effective

November 1, 1999

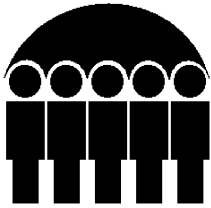
Material Superseded

Remove the following pages from the *Psychiatric Medical Institutions for Children Manual*, and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 4)	June 1, 1993
Table of Contents (page 5)	September 1, 1998
Chapter E	
1-14	June 1, 1993
15-18	March 1, 1999
19-28	June 1, 1993
29	March 1, 1996

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-132

Employees' Manual, Title 8

Medicaid Appendix

January 21, 2000

**PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN MANUAL
TRANSMITTAL NO. 00-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Psychiatric Medical Institutions for Children Manual*, Chapter E, *Coverage and Limitations*, page 8, revised.

Summary

Chapter E is revised to clarify the managed health care section. A child entering a PMIC who is receiving FMAP-related Medicaid is not disenrolled from the Iowa Plan, only from HMO and MediPASS.

Date Effective

Upon receipt.

Material Superseded

Remove from the *Psychiatric Medical Institutions for Children Manual*, Chapter E, and destroy page 8, dated November 1, 1999.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.